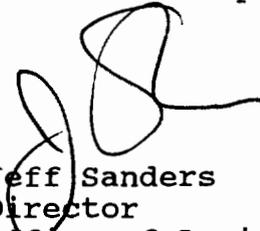


HCFA LEGISLATIVE SUMMARY

June 17, 1991

OMNIBUS BUDGET RECONCILIATION ACT OF 1990

On November 5, 1990, the President signed into law H.R. 5835 the Omnibus Reconciliation Act of 1990 (P.L. 101-508). Summaries of the Medicare, Medicaid, and other relevant provisions are attached.



Jeff Sanders
Director
Office of Legislation and Policy

Attachment



TABLE OF CONTENTS

I. PROVISIONS RELATING TO MEDICARE PART A

PPS Hospitals.....1
Geographic Classification Review Board.....2
Medical Education.....2
PPS-Exempt Hospitals.....3
Freeze in Payments Under Part A.....3
Essential Access Community Hospital Program.....4
Hospital Anti-dumping Provisions.....4
Other Provisions Relating to Part A.....4

II. PROVISIONS RELATING TO MEDICARE PART B

Physicians.....6
Outpatient Departments.....9
Durable Medical Equipment.....10
Clinical Laboratories.....12
Percentage Reduction for Part B Payments.....13
Mammography Screening.....13
Other Provisions Relating to Part B.....13

III. PROVISIONS RELATING TO PARTS A & B

End-Stage Renal Disease.....16
Medicare Secondary Payer.....16
Health Maintenance Organizations.....17
Peer Review Organizations.....19
Advance Directives.....20
Home Health Agencies.....20
Other Provisions Relating to Parts A & B.....20

IV. BENEFICIARY PAYMENTS.....21

V. MEDIGAP REFORM.....21

VI. MEDICAID PROVISIONS

Prescribed Drugs.....25
Private Insurance.....27
Qualified Medicare Beneficiaries.....28
Improvements in Child Health.....28
Voluntary Contributions and State Taxes.....30
Disproportionate Share Hospitals.....30
Federally-qualified Health Centers.....31
Hospice.....31
Disallowances.....31
Substitute Physicians.....32
Home and Community-based Care for the Frail Elderly.....32
Community Supported Living Arrangements for the MR/DD.....34
Spousal Impoverishment.....35
Miscellaneous Eligibility and Coverage Provisions.....35

Health Maintenance Organizations.....	37
Waiver Projects.....	37
Demonstration Projects.....	38
Other Provisions Relating to Medicaid.....	39

VII. NURSING HOME REFORM

Nurse Aide Training Requirements.....	41
Preadmission Screening and Annual Resident Review.....	43
Enforcement Process.....	45
Supervision of Health Care of Residents.....	45
Other Provisions Relating to Nursing Home Reform.....	45

VIII. OTHER PROVISIONS AFFECTING HCFA PROGRAMS

Disabled Widow(er)s.....	48
Federal Employees Health Benefits Program.....	49
Computer Matching.....	49
Veterans' Pensions for NF Residents.....	49
Revenues.....	50

I. PROVISIONS RELATING TO MEDICARE PART A

PPS HOSPITALS

a. Inpatient Capital - Imposes a 15 percent reduction for capital payments to prospective payment system (PPS) hospitals for portions of cost reporting periods occurring in FY91. For FY92 through FY95, aggregate payments to PPS hospitals would be reduced by an amount that equals a 10 percent reduction in capital payments had they been based on reasonable cost. Rural primary care hospitals (RPCHs) and sole community hospitals (SCHs) are exempt from the reduction in FY91. [Sec. 4001]

b. Update Factors

	<u>Large and Other Urban</u>	<u>Rural</u>
FY91:	MB - 2.0	MB - 0.7
FY92:	MB - 1.6	MB - 0.6
FY93:	MB - 1.55	MB - 0.55
FY94:	MB	MB + 1.5
FY95:	MB	An increase that will provide rural hospitals an average standardized amount equal to that of other urban hospitals.

MB is the market basket rate of increase in the prices of goods and services for hospitals. Effective 1/1/91. [Sec. 4002(a) and (c)]

c. Disproportionate Share Payments - Phases in over four years an increase in disproportionate share payments for urban hospitals with over 100 beds. The DSH adjustment is also made permanent. [Sec. 4002(b)]

d. Payments to Rural Hospitals - Eliminates the gap between rural and other urban standardized amounts by the beginning of FY95 by giving rural hospitals a higher update than large and other urban hospitals (see (b) above). Large urban hospitals would continue to have a separate standardized amount, about two percent higher than the amount for all other hospitals. [Sec. 4002(c)]

e. Area Wage Index - From 10/1/90 through 12/31/90, requires use of the wage index in effect on 9/30/90. For 1/1/91 through 10/1/93, requires use of a wage index based solely on the 1988 wage survey. Precludes the phase-in of 1988 wage data included in the PPS regulation published 9/4/90. Also requires the Prospective Payment Assessment Commission (PropAC) to study available data on wages by occupational category and to include recommendations in its March 1991

report on modifying the wage index to take into account occupational mix. [Sec. 4002(d) and 4007(a)]

- f. Extension of Regional Floor - The regional floor, which was due to expire at the end of FY90, is extended through 9/30/93. The Secretary is to study the extent to which differences in non-wage-related prices affect average standardized amounts under PPS. Report to Congress due 6/1/93. [Sec. 4002(e)]
- g. Elimination of Offset for Physician Assistant Services - The OBRA-86 provision authorizing the Secretary to reduce payments to hospitals and skilled nursing facilities (SNFs) to offset duplicate payments for physician assistant services is repealed. [Sec. 4002(f)]
- h. Responsibilities and Reporting Requirements of ProPAC - Expands ProPAC's responsibilities in studying payment policies under PPS and requires them to study the effects on hospitals that serve Medicaid patients. Requires the Commission to submit a report to Congress each June 1. Requires the Secretary to recommend changes in existing reimbursement policies, taking into account ProPAC's recommendations, and to include a written explanation of those recommendations which differ from those of the Commission. [Sec. 4002(g)]

GEOGRAPHIC CLASSIFICATION REVIEW BOARD

- a. Revision of Wage Index for Reclassified Hospitals - If including the wages of all redesignated hospitals in the wage index of the Metropolitan Statistical Area (MSA) to which they are redesignated reduces that MSA's wage index by more than one percentage point, then the original wage index (calculated without the wages of the redesignated hospitals) is applied to hospitals in the MSA. The redesignated hospitals would receive a wage index combining their wages plus the wages of the MSA to which they were redesignated. Effective 1/1/91. [Sec. 4002(h)(1)]
- b. Extension of Due Date - Extends to 11/6/90 the due date for applications for reclassification submitted to the Geographic Classification Review Board. [Sec. 4002(h)(2)(A)]
- c. Secretarial Review of Board Decisions - Clarifies the Secretary's ability to review decisions of the Board. [Sec. 4002(h)(2)(B)]

MEDICAL EDUCATION

- a. Payments for Graduate Medical Education Costs - Prohibits the Secretary from recouping overpayments to hospitals for

graduate medical education until 10/1/91, then limits recoupment to 25 percent in each of the next four years. [Sec. 4004(a) and 4159(a)]

- b. University Hospital Nursing Education - Provides for payment on a pass-through basis, subject to certain limits, to hospitals for clinical training costs for nursing or allied health education programs that are hospital-supported (as opposed to hospital-operated). Among other conditions for reimbursement, the hospital must have claimed and been paid for such costs prior to 10/1/89. The Secretary is prohibited from recouping overpayments made to such hospitals and is required to refund any overpayments already recouped. [Sec. 4004(b) and 4159(b)]

PPS-EXEMPT HOSPITALS

- a. Payment Adjustments for PPS-Exempt Hospitals - Effective 10/1/91, PPS-exempt hospitals will receive an adjustment of 50 percent of the amount by which operating costs exceed their target amounts (which impose a ceiling on the rate of increase in the operating costs per case). This additional amount cannot exceed 10 percent of the target amount. [Sec. 4005(a)]
- b. Development of PPS for Non-PPS Hospitals - Requires the Secretary, by 4/1/92, to develop and report to Congress on a proposal to modify substantially the existing target rate system or to replace it with a prospective system. PropAC is to report with comments on the HHS proposal by 6/1/92. [Sec. 4005(b)]
- c. Appeals of Target Amounts - Amends Contractor Performance and Evaluation Program standards to require speedy processing and implementation of appeals by fiscal intermediaries (75 days). Requires HCFA to decide on such appeals within 180 days. Specifies that, in determining whether to grant a new base period for PPS-exempt hospitals, the Secretary may take into consideration changes in technology and medical practice, differences in the severity of illness among patients, increases in area wage costs higher than increases in such wages nationally, and other factors considered appropriate. Effective upon enactment. [Sec. 4005(c)]

FREEZE IN PAYMENTS UNDER PART A

Payments to hospitals and to hospices are frozen at FY90 levels from 10/20/90 through 12/31/90. [Sec. 4007]

ESSENTIAL ACCESS COMMUNITY HOSPITAL PROGRAM

- a. Border State Priority - In designating rural primary care hospitals (RPCHs) in States not participating in the essential access community hospital (EACH) grant program, the Secretary must give priority to hospitals that are not in a grantee State but participate in a rural health network in a grantee State. [Sec. 4008(d)(1)]
- b. Eligibility of Closed Hospitals - Permits a State to designate as a RPCH, a hospital that closed within the last 12 months but that met the hospital conditions of participation at the time of closure. [Sec. 4008(d)(2)]
- c. Eligibility of Urban Hospitals - Permits a State to designate an urban hospital a RPCH if it is in a particularly large geographic area and its service area is characteristic of rural service areas. [Sec. 4008(d)(3)]

HOSPITAL ANTI-DUMPING PROVISIONS

- a. Civil Monetary Penalties - Changes the standard of proof for imposing civil money penalties against physicians or hospitals to a negligence standard; lowers civil money penalties for small hospitals from \$50,000 to \$25,000. Requires dumping violations to be "gross and flagrant, or repeated" before a physician may be excluded from Medicare. Effective for actions occurring on or after the first day of the sixth month following enactment. [Sec. 4008(b) and 4207(a)]
- b. Elimination of Suspension Authority - Eliminates HCFA's authority to suspend hospital provider agreements for violations. Effective date as in (a). [Sec. 4008(b)]
- c. PRO Review of Anti-dumping Activities - Requires PROs to review alleged violations of hospital anti-dumping provisions when medical issues are raised unless the delay caused by such review would jeopardize the health and safety of individuals. Effective date as in (a). [Sec. 4207(a)]
- d. Whistleblower Protection - Clarifies whistleblower protections for employees reporting dumping incidents. Effective upon enactment. [Sec. 4207(m)(3)]

OTHER PROVISIONS RELATING TO PART A

- a. Hospice Benefit Extension - Eliminates the 210-day limit on the number of days a beneficiary may receive hospice benefits, provided physician certification and recertification occur at required intervals. Effective 1/1/90. [Sec. 4006]

- b. Waiver of Liability for SNFs and Hospices - Both waivers of liability are extended through 12/31/95. (The SNF waiver was due to expire 10/31/90; the hospice waiver, 11/1/90.) [Sec. 4008(a)]
- c. Inspector General Study on Hospital Employment of Physicians - The Inspector General is to study the effects of State laws prohibiting the employment of physicians by hospitals on the availability of emergency care and to submit a report to Congress one year after enactment. [Sec. 4008(c)]
- d. Skilled Nursing Facility Routine Cost Limits - Requires the Secretary to update cost limits for routine service costs for freestanding and hospital-based skilled nursing facilities (SNFs) for cost reporting periods beginning 10/1/89 using submitted cost reports for periods ending not earlier than 1/31/88 and not later than 12/31/88. The Secretary is also required to rebase SNF cost limits for cost reporting periods beginning 10/1/92 and every two years thereafter. Effective as if included in OBRA-89. [Sec. 4008(e)]
- e. Clarification of Secretarial Waiver Authority
 - o Permits a demonstration in Montana of rural limited service hospitals, designed to maintain access to low-intensity acute, emergency, and primary care in remote rural areas. [Sec. 4008(i)]
 - o Permits demonstrations of integrated Medicare and Medicaid prospective, case-mix adjusted payment systems in a number of States, building on a pilot project in Wisconsin. [Sec. 4008(i)]
 - o Revises tests of compliance with PPS waivers for the Finger Lakes Area Hospital Corporation and the State of Maryland. [Sec. 4008(f) and 4008(i)]
- f. Determination of Reasonable Costs Relating to Swing Beds - Provides that swing-bed rates, previously based on Medicaid payments, are to be based on Medicare payments for free-standing SNFs in the same region, holding harmless those facilities now paid higher rates. Effective 10/1/90. [Sec. 4008(j)]
- g. PPS for Skilled Nursing Facilities - Requires the Secretary to develop a prospective payment system for SNFs. Research studies are due 4/1/91; proposal due 9/1/91. ProPAC to provide analysis and comments by 3/1/92. [Sec. 4008(k)]
- h. Review of Rural Hospital Regulations - Requires the Secretary to study how to relieve the regulatory burden on rural

hospitals, especially in terms of staffing requirements.
Report due to Congress 4/1/92. [Sec. 4008(1)]

Note: Medicare provisions relating to nursing home reform are described below in part VII. For summary of a provision relating to which hospital services are included in DRG payments, see "DRG Payment Window," Sec. 4003, p. 11.

II. PROVISIONS RELATING TO MEDICARE PART B

PHYSICIANS

- a. Overvalued Procedures - Effective 1/1/91, the same 245 overvalued procedures reduced in OBRA-89 are again reduced. The reduction is the same amount as the procedures were reduced in 1990: that is, one-third of the amount, up to a maximum of 15 percent, that the 1989 national average prevailing charge exceeded an adjusted local amount. [Sec. 4101(a)]

In addition, effective 1/1/91, all physician procedures, other than these overvalued procedures, evaluation and management services, and the radiology, anesthesia, pathology and diagnostic test technical components reduced elsewhere in OBRA-90, are reduced by 6.5 percent. [Sec. 4101(b)]

- b. Radiology Services - Effective 1/1/91, radiology fee schedule conversion factors in local areas will be reduced up to 9.5 percent, based on comparisons with adjusted local amounts. The adjusted local amounts will be derived by reducing the national average conversion factor by 13 percent and applying geographic adjustment factors (different adjustments will be used for professional and technical components). Portable x-rays are excluded from payment reductions. [Sec. 4102(a)]

A floor is established at 60 percent of the national average conversion factor. In 1991 and 1992, radiology services are given a special transition to the Medicare radiology fee schedule. [Sec. 4102 (a) and 4102 (b)]

Reduces prevailing charges for radiology services performed by non-radiologists to the radiologist fee schedule, except for nuclear medicine services furnished by nuclear medicine physicians, effective 1/1/91. [Sec. 4102(c)]

Effective 1/1/91, payments for the technical components of CAT scans and MRI are reduced by 10 percent. [Sec. 4102(d)]

The same transition rules that applied for nuclear medicine physicians in 1990 will apply in 1991. A special rule relating to billing for interventional radiology services

introduced by OBRA-89 is continued for an additional year. Effective 1/1/91, carriers are prohibited from applying comparability rules to payments under fee schedules. [Sec. 4102(e), 4102(g) and 4102(h)]

- c. Anesthesia Services - Effective 1/1/91, anesthesia fees will be reduced up to 15 percent based on comparisons with adjusted local amounts. The adjusted local amounts will be derived by reducing the national average conversion factor by 7 percent and applying geographic adjustment factors. A floor is established at 60 percent of the national average conversion factor. [Sec. 4103(a)]

The provision that reduces base units for anesthesiologist supervision of concurrent anesthesia services is continued for five additional years. [Sec. 4103(b)]

- d. Pathology Services - Effective 1/1/91, prevailing charges for physician pathology services in all localities will be reduced by 7 percent. An exception is provided for independent laboratories that bill for both professional and technical components. The requirement for a separate pathology fee scheduled to be effective 1/1/91 is repealed. [Sec. 4104]

- e. Physician Update for 1991 - The physician update for prevailing charges in 1991 is set at two percent for primary care services and 0 percent for all other services. Customary charges for 1991 are updated for primary care services and frozen for all other services. [Sec. 4105(a)]

Effective 1/1/91, the primary care floor is raised from 50 percent to 60 percent of the national average. In order to avoid out-year costs, this provision is to be implemented in a budget neutral fashion under the fee schedule. [Sec. 4105(b)]

The 1992 physician update is reduced by 0.4 percentage points from what it would otherwise be. [Sec. 4105(a)]

A formula is specified to determine the Medicare Volume Performance Standard (MVPS) for fiscal year 1991: using the baseline rate of increase, subtract the effects of OBRA-90, and reduce that figure by two percentage points. The Secretary is required to determine and publish the FY91 MVPS figure within 45 days of enactment. [Sec. 4105(c)]

- f. New Physicians and Other Practitioners - The prior new physician policy is extended and expanded to include other practitioners. Medicare payment in the first year of practice is 80 percent of the prevailing charge or fee schedule, 85 percent in the second year, 90 percent in the third year, and 95 percent in the fourth year. [Sec. 4106]

- g. Assistants-at-Surgery - Effective 1/1/91, payment for physicians as assistants-at-surgery is limited to 16 percent of the surgical global fee. In addition, no payment will be made for assistants-at-surgery for procedures in which a physician is currently used less than five percent of the time. [Sec. 4107]
- h. Technical Component of Diagnostic Tests - Effective 1/1/91, payment for the technical component of certain diagnostic tests specified by the Secretary (but excluding clinical diagnostic laboratory tests, radiology services, and diagnostic tests reduced by the overpriced procedures provision) is capped at the median across all localities. [Sec. 4108]
- i. Interpretation of Electrocardiograms - Effective 1/1/92, a separate payment for interpretation of an electrocardiogram will not be made if the EKG was ordered or performed as part of a visit or consultation. [Sec. 4109]
- j. Reciprocal Billing Arrangements - Allows substitute billing by one physician for the services of another "substitute" physician in reciprocal billing arrangements for visit services (including emergency visits and related services). Substitute billing is limited to 60 days. [Sec. 4110; see sec. 4708 for related Medicaid provision.]
- k. Study of Prepayment Medical Review Screens - The Secretary is required to conduct a study of the effect of the public release of the parameters used by carriers to screen physician claims in at least six carrier areas. A report to Congress is due on 10/1/92. [Sec. 4111]
- l. Practicing Physicians Advisory Council - Establishes a 15-member advisory council consisting of practicing physicians that is required to meet once every three months to discuss proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary. To the extent feasible, the consultation would occur before the publication of the proposed changes. [Sec. 4112]
- m. Study of Aggregation Rule for Claims - Requires the Secretary to study the effect of allowing two or more physicians to aggregate claims, for appeals purposes, when the claims involve common issues of law and fact. The study is to be conducted by at least four carriers; a report is due on 12/31/92. [Sec. 4113]
- n. Utilization Screens for Physician Visits in Rehabilitation Hospitals - Requires the Secretary to issue guidelines to assure a uniform level of review of physician visits to

patients of a rehabilitation hospital after the medical review screening parameter has been exceeded. [Sec. 4114]

- o. Study of Regional Variations in Impact of Medicare Physician Payment Reform - Requires the Secretary to conduct a study, by 7/1/92, of geographic variations in Medicare reasonable charges that are not attributable to physician practice costs, the extent to which geographic practice cost indices (GPCIs) reflect variations in practice expenses, the impact of transition to the fee schedule on access in areas that experience a disproportionately large reduction in payments under the fee schedule, and appropriate adjustments to assure adequate access. [Sec. 4115]
- p. Limitation on Beneficiary Liability - The balance billing limit for the so-called evaluation and management services is increased from 125 percent to 140 percent of the prevailing charge for 1991. [Sec. 4116]
- q. Statewide Fee Schedule Areas - Requires the Secretary to treat Nebraska or Oklahoma as statewide areas under the fee schedule, if the States meet certain requirements. [Sec. 4117]
- r. Technical Corrections - A number of technical and other changes are made including: making the MVPS multiplicative instead of additive; requiring periodic review and adjustment of the geographic practice cost indices; eliminating the prohibition regarding use of time in the definition of medical visits prior to 1/1/93; adding a behavioral offset to the MVPS default price factor; clarifying that there are separate default MVPS's for surgical and non-surgical services; clarifying that comparability and inherent reasonableness do not apply under the fee schedule; repealing several reports to Congress that are no longer needed; expanding the Physician Payment Review Commission mandate; and conforming the statutory effective dates to dates certain provisions were actually implemented. [Sec. 4118]

OUTPATIENT DEPARTMENTS

- a. Outpatient Capital - Payments for outpatient capital are reduced by 15 percent for portions of cost reporting periods in FY91 and by 10 percent in FY 1992-1995. (These are the same cuts as for inpatient capital.) Sole community hospitals and rural primary care hospitals are exempt for all years. [Sec. 4151(a)]
- b. Outpatient Services - Payment for those hospital services paid on a reasonable cost basis are cut by 5.8 percent in FY 1991-1995. Sole community hospitals and rural primary care

hospitals are exempt. [Sec. 4151(b)(1)]

- c. Ambulatory Surgical Center and Radiology Services - Effective 1/1/91, payments for surgical services on the ambulatory surgical center (ASC) list of procedures and for radiology services are based on a blend of 42 percent of the lower of the hospital's costs or charges and 58 percent of the ASC payment amount or the radiology fee schedule amount, respectively (instead of the previous 50/50 blend). [Sec. 4151(c)(1)(A) and 4151(c)(2)]
- d. Eye/Ear Hospital Extension - The special blend for eye and ear hospitals of 75 percent of the lower of the hospital's costs or charges and 25 percent of the ASC payment amount is maintained through cost reporting periods beginning before 1/1/95. [Sec. 4151(c)(1)(B)]
- e. Intraocular Lenses - Maintains the \$200 intraocular lens allowance for ASCs provided for in regulations as part of the ASC payment amount through 12/31/92. [Sec. 4151(c)(3)]
- f. DRG Payment Window - Outpatient services that are related to an inpatient admission and are provided by the hospital in the three-day period prior to the admission are not to be separately reimbursable under Part B. (No offsetting adjustment is made in inpatient hospital payments.) This policy is phased in, starting with diagnostic services, effective 1/1/91, and other related services (as specified by the Secretary), 10/1/91. The prior policy of denying payment for all outpatient services provided on the day before the date of an inpatient admission is continued through 9/30/91. [Sec. 4003]
- g. Prospective Payment System Reports - The Secretary is required to report research findings by 1/1/91 related to the development of a prospective payment system for hospital outpatient services and to submit a final report with a proposal for such a system by 9/1/91. The Prospective Payment Assessment Commission is required to submit an analysis of the HHS proposal by 3/1/92. [Sec. 4151(b)(2)]

DURABLE MEDICAL EQUIPMENT

- a. Payment for Transcutaneous Electrical Nerve Stimulators- Payment for transcutaneous electrical nerve stimulators (TENS), which was reduced by 15 percent by OBRA-89, is reduced by an additional 15 percent, effective 1/1/91. [Sec. 4152(a)(1)]
- b. Seatlifts - Effective 1/1/91, coverage for seatlifts is limited to the seatlift mechanism, thus excluding payment for

an associated chair. [Sec. 4152(a)(2)]

- c. National Limits and Floors - National payment limits and floors will be phased-in over three years, starting in 1991. The national upper payment limit will be based on the weighted average of all payment amounts for each item, and the floor will be based on 85 percent of the weighted average. All categories of durable medical equipment (DME) except prosthetic and orthotic devices are subject to these limits. [Sec. 4152(b)]
- d. Rebasing Capped Rental Fee Schedule - The basis of the existing fee schedule for capped rental items is changed from submitted charges to average reasonable charges. This is done by calculating the difference between submitted charges and average reasonable charges in each carrier service area in 1988 and applying this reduction factor to the existing fee schedule amounts. Effective 1/1/91. [Sec. 4152(b)(2)(A)]
- e. Update - The update is reduced by one percentage point in 1991 and 1992. [Sec. 4152(b)(4)]
- f. Reduction in Rental Payments - For capped rental items, the maximum amount of rental payments is reduced from 150 percent of the purchase price to 120 percent. During the first three months of a rental, payment will be made at 10 percent of the purchase price, and during the next 12 months, payment will be made at 7.5 percent of the purchase price for total payments of 120 percent. Effective 1/1/91. [Sec. 4152(c)(1)]
- g. Purchase Option - For capped rental items, previously provided on a rental basis only, beneficiaries will be given an option to purchase the item in the tenth month of rental. For power-driven wheelchairs, a purchase option will also be provided in the first month. Effective 1/1/91. [Sec. 4152(c)(2)(D)]
- h. Replacement - Institutes a replacement policy for capped rental items. The Secretary is required to establish a reasonable useful lifetime for these items, which will generally be five years unless an alternative useful lifetime is more appropriate. When the reasonable useful lifetime has been reached or the item is lost or damaged, Medicare payment may be made for a replacement item. Effective 1/1/91. [Sec. 4152(c)(2)(F)]
- i. Power-Driven Wheelchairs - Payment for power-driven wheelchairs is moved from the inexpensive and frequently purchased category of DME to the capped rental category. (OBRA-89 had moved these items from capped rental to the frequently purchased category.) Effective 1/1/91. [Sec. 4152(c)(4)(A)]

- j. Customized Wheelchairs - The Secretary is required to publish a definition of customized wheelchairs by 1/1/92; otherwise, a statutory definition will become effective. [Sec. 4152(c)(4)(B)]
- k. Enteral and Parenteral Update - A zero update is provided in 1991 for enteral and parenteral nutrients, equipment and supplies. [Sec. 4152(d)]
- l. Prior Authorization - The carriers are required to make advance determinations of coverage of over-utilized items listed by the Secretary. This list must include seat-lift mechanisms, TENS, and motorized scooters. Effective 1/1/91. [Sec. 4152(e)]
- m. Distribution of Medical Necessity Forms - Suppliers are prohibited from providing to physicians or beneficiaries completed or partially completed medical necessity forms. Effective 1/1/91. [Sec. 4152(f)]
- n. Oxygen Retesting - Oxygen-receiving beneficiaries with an initial arterial blood gas value at a partial pressure of 55 or greater or an arterial oxygen saturation at or above 89 percent are required to be retested during the last 30 days of their initial 90 days of oxygen. No further payment may be made for these beneficiaries without retesting and physician recertification. The Secretary may establish alternative values, pressures, or criteria that he finds to be more appropriate. Effective 1/1/91. [Sec. 4152(g)]
- o. Orthotics and Prosthetics - Payment for orthotics and prosthetics will continue to be made on the basis of the current fee schedule methodology; however, the transition to regional fee schedules is delayed for one year. A zero update is provided in 1991. The national payment limitation and floors established for items of DME will not apply to orthotics and prosthetics. GAO is required to study the feasibility of establishing a separate fee schedule for prosthetics and orthotics provided by suppliers who provide professional services. [Sec. 4153(a) and 4153(c)]
- p. Eyeglasses - Provides that Medicare covers one pair of eyeglasses or contact lenses furnished following cataract surgery involving insertion of an intraocular lens. Effective 1/1/91. [Sec. 4153(b)]

CLINICAL LABORATORIES

- a. Update - Changes the annual update factor for the laboratory fee schedules from the Consumer Price Index for All Urban Consumers (CPI-U) to a straight two percent for 1991-1993.

[Sec. 4154(a)]

- b. National Limit - The national limit for each test, now set at 93 percent of the median of the carrier fee schedule amounts, is reduced to 88 percent of the median of the carrier fee schedule amounts, effective 1/1/91. [Sec. 4154(b)]
- c. Mandatory Assignment - Clarifies that clinical laboratory tests in all settings (including physician office laboratories) are subject to assignment. [Sec. 4154(c)]
- d. Shell Labs - Modifies the basis for the existing test on whether claims for laboratory services that are performed by a laboratory other than the laboratory submitting the bill could be paid by Medicare. One element of the test will be based on the number of requests for testing rather than the number of bills submitted to Medicare, effective 1/1/91. [Sec. 4154(e)]

PERCENTAGE REDUCTION FOR PART B PAYMENTS

All payments to providers, physicians, and suppliers are reduced by two percent for November and December of 1990; does not apply to HMOs with risk contracts. [Sec. 4158]

MAMMOGRAPHY SCREENING

Establishes coverage of screening mammography, subject to frequency limits, quality standards, and special payment rules, for Medicare beneficiaries. Medicare will pay the lesser of 80 percent of the following charges per individual screening: a physician's actual charge, the fee schedule amount, or \$55. Effective 1/1/91. [Sec. 4163]

OTHER PROVISIONS RELATING TO PART B

- a. Nurse Practitioner Services - Adds coverage of and extends direct payment for nurse practitioner and clinical nurse specialist services, previously limited to skilled nursing facilities or nursing facilities, to all settings in rural areas. Effective 1/1/91. [Sec. 4155]
- b. Injectable Osteoporosis Drugs - Adds coverage of injectable drugs used for treatment of post-menopausal osteoporosis where the patient is confined to the home and incapable of self-administering the drug. Applies to services provided on or after 1/1/91, and on or before 12/31/95. The Secretary must study the effects of the coverage of osteoporosis drugs and report to the Congress by 10/1/94. [Sec. 4156]

c. Psychologist Services - Extends direct payment for qualified psychologist services to hospital inpatient settings. Effective 1/1/91. [Sec. 4157]

d. Certified Registered Nurse Anesthetists - The conversion factor for non-medically and medically directed certified registered nurse anesthetists (CRNAs) is set in statute for calendar years 1991 through 1996. The conversion factors are specified as:

CY	Non-medically directed	Medically directed
1991	\$15.50	\$10.50
1992	15.75	10.75
1993	16.00	11.00
1994	16.25	11.25
1995	16.50	11.50
1996	16.75	11.70

After 1996, the conversion factors will be updated by the update factor applicable for anesthesia services furnished by physicians. The conversion factors are geographically adjusted, and existing conversion factors for non-medically directed CRNAs are subject to transition rules. The conversion factors are limited by the conversion factor applicable for anesthesia services furnished by physicians. [Sec. 4160]

e. Federally Qualified Health Centers and Rural Health Clinics - Expands Medicare coverage to services provided in federally qualified health centers (FQHCs); expands scope of services available to Medicare beneficiaries to include preventive primary health care, but only when provided by a FQHC; increases payments for FQHCs by making payment in the same way as for rural health clinics (RHCs), that is, on a reasonable cost basis; authorizes the Secretary to relax the requirement that 50 percent of staff at FQHCs and at RHCs be non-physician practitioners. Applies to services furnished on or after 10/1/91. [Sec. 4161]

f. Community Mental Health Centers - Establishes coverage of partial hospitalization services in community mental health centers. (Partial hospitalization services are intensive ambulatory services that prevent relapse or hospitalization, including occupational therapy, drugs, counseling, and diagnostic services.) Applies to services provided on or after 10/1/91. [Sec. 4162]

g. Prevention Demonstrations - Extends existing demonstrations from four to five years, partly to permit longer follow-up of existing cases. Changes due dates of the preliminary report to Congress to 4/1/93 and of the final report to 4/1/95. Increases authorization by \$1.6 million, and authorizes an additional \$3 million for a comprehensive evaluation of long-

term effects. [Sec. 4164(a)(1)]

h. Alzheimer's Disease Demonstration Projects - Extends the existing projects for one year; increases authorization by \$15 million for the projects and \$1 million for the evaluation. [Sec. 4164(a)(2)]

i. Physician Referrals and Ownership Disclosure [Sec. 4164(b) and 4207(e)]

- o Permits physicians who have a financial relationship with a hospital to refer patients to the hospital laboratory, as long as the relationship does not involve the provision of clinical laboratory services. (This is an exemption from the general prohibition on referring patients to laboratories in which the physician has an ownership interest or financial relationship.) Effective for referrals made on or after 1/1/92.
- o Extends the due date for regulations implementing OBRA-89 physician referral provisions to 10/1/91.
- o Requires the Secretary to report on utilization differences between beneficiaries served by entities (other than clinical laboratories) in which referring physicians have a financial interest and beneficiaries served by other entities, due 6/30/92.
- o Permits the Secretary to waive on a State-by-State basis the requirements that facilities report ownership information, subject to certain limitations. All clinical labs must comply with the reporting requirements. In at least ten States, hospitals, parenteral and enteral suppliers, end stage renal disease facilities, ambulance service suppliers, physical therapy providers, and diagnostic imaging service providers must also report.
- o Requires the Secretary to publish a directory of unique physician identification numbers by 3/31/91, to help identify referring physicians. [Sec. 4164(c).]
- o No payment may be made to Part B providers unless they have furnished the Secretary with information identifying the following:
 - + All persons with an ownership interest in the provider or in a subcontractor partially owned by the provider;
 - + For each owner or managing employee, the identity of any other provider receiving Medicare payment in which the individual had an ownership or control interest during the last three years.

- + Any sanctions HHS has imposed against any of the provider's owners or managing employees.

Criminal penalties may be imposed for providing false information; failure to provide the required information not only precludes Part B payments but also is grounds for exclusion from the program.

Reporting deadlines: 1/1/92, for new Part B providers, and 1/1/93 for providers who were already providing Medicare Part B items or services as of November 5, 1990.

III. PROVISIONS RELATING TO PARTS A & B

END-STAGE RENAL DISEASE

- a. Composite Rate - The composite rate is maintained at the current level through 1990, and is increased by \$1, effective 1/1/91. PropAC is required to conduct a study on the composite rate and to submit a report by 6/1/92, and to submit an annual report every March 1 thereafter. [Sec. 4201(a) and 4201(b)]
- b. Payment for Erythropoietin - Payment for erythropoietin (EPO) to facilities and suppliers is based on \$11 per 1,000 units beginning 1/1/91. This rate replaces the current two-tiered payment system of \$40 for dosages of less than 10,000 units and \$70 for dosages of 10,000 or more units. In subsequent years, the Secretary will determine the rate, limited by the 1991 rate increased by the GNP deflator. Payment to physicians is on a reasonable charge basis. [Sec. 4201(c)]
- c. Self-administered EPO - Provides for coverage of self-administered EPO for home dialysis patients, at the payment rate discussed above, subject to methods and standards to be established by the Secretary for the safe and effective use of such drug. Effective 7/1/91. [Sec. 4201(d)]
- d. Home Aide Demonstration - Mandates a three-year demonstration to provide payment for home dialysis staff assistants for up to 800 patients. A preliminary report is due 12/1/92, and a final report is due 12/31/95. [Sec. 4202]

MEDICARE SECONDARY PAYER

- a. IRS/SSA/HCFR Data Match - Extends the match of HCFR data with data from the Internal Revenue Service and the Social Security

Administration to assist in the identification of individuals with primary group health plan coverage. The data match is extended to include tax years 1990 through 1994, and the requirement for employers to respond to HCFA inquiries for health care coverage information is extended through FY95. [Sec. 4203(a)]

- b. Medicare Secondary Payer for Disabled Beneficiaries - Extends the medicare secondary payer (MSP) provision for disabled beneficiaries through FY95. [Sec. 4203(b)]
- c. MSP for ESRD Beneficiaries [Sec. 4203(c)]
 - o Changes the beginning of the period in which Medicare is secondary payer for end-stage renal disease (ESRD) beneficiaries to the individual's first month of Medicare entitlement (or eligibility if earlier) rather than the first month of dialysis. This change makes Medicare the secondary payer during a fixed period of 12 months for all ESRD beneficiaries. Previously, Medicare was secondary for a period that varied from 9 to 12 months depending upon whether entitlement was based on a kidney transplant or a course of dialysis and if the beneficiary had enrolled in a self-care dialysis training program. Effective upon enactment.
 - o Expands the modified 12-month period (see above) during which Medicare is secondary for ESRD beneficiaries to 18 months. This change is effective for items and services furnished on or after 2/1/91 with respect to individuals who began their 12-month period on or after 2/1/90. The extension is time-limited and expires on January 1, 1996. GAO is required to study the impact of this extension on access to employment and on the amount of cost-sharing required by group health plans.
- d. Prohibition Against Financial Incentives - Prohibits employers from offering financial or other incentives for individuals not to enroll (or to terminate enrollment) in a group health plan that would be required to pay primary to Medicare unless such incentives are offered to all individuals eligible for coverage under the plan. Civil money penalties can be imposed for violation of this provision. Effective upon enactment. [Sec. 4204(g)]

HEALTH MAINTENANCE ORGANIZATIONS

- a. Regulation of Incentive Payments to Physicians - Health maintenance organizations (HMOs) are prohibited from making specific payment to physicians or physician groups as an inducement to reduce or limit medically necessary services

provided to a specific individual. If a HMO's physician incentive plan places a physician or physician group at substantial financial risk for services that they do not provide, the HMO must provide stop-loss protection based on standards developed by the Secretary and must conduct periodic surveys of Medicare enrollees regarding satisfaction with access and quality. Penalties include civil money penalties and suspension of enrollment or payment. Effective with 1992 contracts. [Sec. 4204(a)]

- b. Requirements with Respect to Actuarial Equivalence of AAPCC - The Secretary must revise or replace the adjusted average per capita cost (AAPCC) methodology so that the methodology more accurately predicts the actual services used by, and the annual medical expenditures of, the beneficiaries enrolled in a specific organization, and which explains at least 15 percent of the variation in health care utilization and costs among individuals. The Secretary must submit a proposal to Congress by 1/1/92 and publish a proposed rule by 3/1/92 and a final rule by 8/1/92. The new payment methodology will apply to 1993 contracts. [Sec. 4204(b)]
- c. Application of National Coverage Decisions - Effective in 1991, plans with risk contracts would no longer have to absorb increased costs resulting from national coverage decisions made by the Secretary that involve significant costs and that are announced after the promulgation of AAPCC rates. Plans could bill Medicare for these benefits on a fee-for-service basis during the year to which the rates apply. (This provision does not apply to coverage changes made by legislation.) [Sec. 4204(c)]
- d. Payments for Services Furnished by Non-Contract Providers - Extends to all physicians' services and renal dialysis services, the OBRA-89 provision that limits the amount that non-contract providers can charge HMOs for services provided to HMO enrollees to what Medicare would otherwise have paid. Effective 1/1/91. [Sec. 4204(d)]
- e. Retroactive Enrollment - Permits payments to a risk HMO to be retroactively adjusted to reflect enrollments in the HMO through an employer group health plan that occurred up to 90 days earlier, subject to certain conditions. Effective 1/1/91. [Sec. 4204(e)]
- f. Study of Chiropractic Services - The Secretary must report to Congress by 1/1/93 on the availability of Medicare covered chiropractic services to HMO enrollees. [Sec. 4204(f)]
- g. Enrollment in Part A for HMO Members - Creates a special enrollment period for premium Part A for individuals enrolled in HMOs under section 1876. This period spans from any month

in which the individual is enrolled for at least one day to the last day of the eighth consecutive month in which the individual is at no time enrolled in the HMO. Effective 2/1/91. [Sec. 4008(g)]

PEER REVIEW ORGANIZATIONS

a. Corrective Action Plans

- o Limits a PRO's ability to recommend sanctions if a provider or practitioner has successfully completed a corrective action plan.
- o The Secretary is to consider a practitioner or provider's unwillingness or lack of ability to complete a plan, during the period before the PRO submitted its sanction recommendation, in determining whether to impose a sanction.

Effective for initial determinations made by PROs on or after the date of enactment. [Sec. 4205(a)]

b. Optometrists and Podiatrists - To the extent necessary and appropriate, PROs must use these practitioners in the review of cases relating to these specialties. Effective for contracts entered into or renewed following enactment. [Sec. 4205(b)]

c. Coordination and Information Sharing

- o The Secretary is to develop a plan to coordinate review activities of PROs and carriers, to be submitted to Congress by 1/1/92. [Sec. 4205(c)]
- o Requires the PRO to notify State licensing boards when it (1) sends an initial sanction notice to a physician and (2) submits an initial sanction recommendation to the Inspector General. Effective 60 days after enactment. [Sec. 4205(d)]
- o Requires the Secretary to notify State medical boards of all exclusions from Medicare and Medicaid resulting from PRO recommendations. Effective 60 days after enactment. [Sec. 4205(d)]

d. Hospital Anti-Dumping - See page 4.

e. Confidentiality - Increases confidentiality protections relating to documents produced in connection with PRO deliberations. Effective upon enactment. [Sec. 4205(e)]

- f. Liability - Clarifies that current liability protection for PRO employees also includes protection for the PRO itself. Effective upon enactment. [Sec. 4205(f)]

ADVANCE DIRECTIVES

Providers and HMOs must maintain written policies and procedures on advance directives, including "living wills" and durable powers of attorney. They must provide such information in writing to all patients, in addition to information about the individual's rights under State law. Providers and HMOs must also provide education for their staffs and the community on issues concerning advance directives. This provision does not override State laws which allow providers as a matter of conscience to object to the implementation of advance directives. Effective date: The first day of the month beginning more than one year after enactment. [Sec. 4206; see sec. 4751 for Medicaid provisions]

HOME HEALTH AGENCIES

- a. Extension of Home Health Waiver of Liability - Extends the waiver of liability until 12/31/95 (previously due to expire 11/1/90). [Sec. 4207(b)(3)]
- b. PPS for Home Health Agencies - Requires the Secretary to submit research findings to Congress by 4/1/93 on the feasibility of modifying the current payment system or replacing it with a PPS-type system. A proposal is due to Congress 9/1/93; PropAC is to report with comments on the HHS proposal by 3/1/94. [Sec. 4207(c)]
- c. Home Health Wage Index - Repeals the home health wage index and substitutes the hospital wage index, calculated without regard to hospital reclassifications, for determination of payments to home health agencies. Provides for a two-year transition period. Wage index updates are to be made on a budget neutral basis. [Sec. 4207(d)]
- d. Home Health Agency Deficiency Standards - Revises the standards for approval of home health aide training programs offered by or in home health agencies. Effective as if included in OBRA-87. [Sec. 4207(j)]

OTHER PROVISIONS RELATING TO PARTS A & B

- a. Baseline Protection Amendment - Extends the existing prohibition on regulations, instructions, or policies that save more than \$50 million in a Federal fiscal year to 9/30/93, or if later, the last fiscal year for which there is

a maximum deficit amount specified under the Congressional Budget and Impoundment Control Act of 1974 of more than \$50 million. [Sec. 4207(b)(1)]

- b. Prohibition on Payment Delay - Prohibits publication of regulations or instructions that are intended to slow down or speed up claims payment. [Sec. 4207(b)(2)]
- c. Extension and Expansion of Waivers for Social Health Maintenance Organizations - Extends the four existing social health maintenance organization demonstration sites through 1995. Changes due date of final report to Congress on these sites to 3/31/96. Requires four more sites to be added for specific purposes; increases authorization by \$3.5 million. [Sec. 4207(b)(4)]
- d. Case Management Demonstration Project - Specifically reinstates three demonstrations originally mandated by the Medicare Catastrophic Coverage Act (MCCA) and terminated when MCCA was repealed. [Sec. 4207(g)]
- e. User Fee Prohibition - Prohibits use of user fees to cover the costs of surveys and certification of nursing facilities and other providers. [Sec. 4207(h)]
- f. Sanction Authority - Allows the Secretary to delegate sanction authority under sections 1128 and 1128A of the Social Security Act, including the exclusion of individuals, organizations, agencies or other entities from participating in the Medicare program, and the imposition of civil monetary penalties on participants when applicable, to the Inspector General. [Sec. 4207(i); see sec. 4753 for a parallel provision in Medicaid.]

IV. BENEFICIARY PAYMENTS

- a. Part B Premium - Sets premium levels for calendar years 1991 through 1995 in statute: \$29.90 in 1991, \$31.80 in 1992, \$36.60 in 1993, \$41.10 in 1994 and \$46.10 in 1995. (These figures represent approximately 25 percent of program costs according to Congressional Budget Office estimates at the time of passage of OBRA-90.) [Sec. 4301]
- b. Part B Deductible - Permanently increases the deductible from \$75 to \$100, starting 1/1/91. [Sec. 4302]

V. MEDIGAP REFORM

- a. Standardization [Sec. 4351]
 - o The National Association of Insurance Commissioners (NAIC)

- o States with approved programs must regulate Medigap premiums and must establish policies for holding public hearings before approving premium increases. Effective one year after enactment. [Sec. 4356(b)].
- o All insurers must offer an open enrollment period, with no medical underwriting, to beneficiaries during their first six months of Part B enrollment, subject to a \$5,000 civil money penalty. Effective one year after enactment. [Sec. 4357(a)]
- o Sellers must provide beneficiaries with a standardized outline of benefits prior to the sale of a Medigap policy, subject to the same civil money penalties as described in 4351(a)(3).

f. Medicare SELECT [Sec. 4358]

- o Medigap policies involving networks of preferred providers may be sold in 15 States chosen by the Secretary, for a three-year period beginning in 1992.
- o Medicare SELECT policies may be structured to pay lower supplemental benefits, such as deductibles and copayments, for care rendered outside the plan's provider network, however, full benefits under the policy must be provided for out-of-network services obtained when urgently needed. A policy holder will receive full Medicare benefits for care rendered either inside or outside the network.
- o Each provider network must offer sufficient access and have a quality assurance program. Offerers must provide purchasers with a full explanation of the policy's coverage restrictions and have purchasers sign acknowledgments of receipt of this explanation, as well as other requirements, subject to a \$25,000 civil money penalty.

g. Beneficiary Assistance

- o The Secretary is to provide beneficiary assistance on Medicare, Medigap and Medicaid through local Federal offices, community outreach programs, and a toll-free hotline. Effective upon enactment. [Sec. 4359 and 4361].
- o The Secretary is required to make grants to States for beneficiary health insurance counseling programs that meet detailed criteria. \$10 million is authorized for this purpose for each of fiscal 1991, 1992 and 1993. [Sec. 4360]
- o The Secretary is authorized to conduct a demonstration in up to five States to establish statewide toll-free hotlines

to provide State-specific information on Medicare, Medigap and Medicaid. Effective upon enactment. [Sec. 4361(b)]

Effective dates: Unless otherwise noted above, provisions relating to Medigap reform become effective in most States on the earlier of (1) the date the State adopts new standards developed by NAIC to conform with OBRA-90 (or Federal standards developed by the Secretary should the NAIC fail to do so) or (2) one year after the NAIC (or the Secretary) adopts these standards. A delay is provided for States where the legislature is not scheduled to meet in 1992.

VI. MEDICAID PROVISIONS

PRESCRIBED DRUGS

- a. In General - Subject to certain exceptions, Federal financial participation (FFP) is denied for the prescription drugs of manufacturers that do not enter into rebate agreements with the Secretary to provide specified rebates to States on a quarterly basis. States that offer prescription drug coverage under their Medicaid programs must cover all of the drugs of any manufacturer operating under such an agreement, with certain statutorily specified exceptions that may be excluded from coverage or otherwise restricted. These requirements are effective 1/1/91.

Drugs not subject to denial of FFP are: (1) certain drugs that the State determines essential to the health of Medicaid beneficiaries and the use of which the State subjects to prior authorization and (2) vaccines.

This provision imposes different pricing rules for two general categories of drugs. First are "brand name" drugs, "single source" drugs, and "innovator multiple source" drugs. Single source drugs are those manufactured under patent; innovator multiple source drugs are those manufactured by the initial patent holder, but for which the patent has expired. The second group is "generic drugs," otherwise known as "non-innovator multisource" drugs, that are approved by the Food and Drug Administration for substitution for these brand name drugs.

- b. Manufacturer Reporting Requirements - To allow the calculation and monitoring of rebate amounts, drug manufacturers must report their average manufacturer price (AMP) and, in addition, manufacturers must report their "best price" for each covered drug to the Secretary on a quarterly basis. Manufacturers are subject to civil monetary penalties for false reporting. The AMP is drug-specific and is the average

price paid during a calendar quarter to the manufacturer for drugs distributed by wholesalers that deal with retail pharmacies.

- c. Sole Source and Innovator Multiple Source Rebates - In CYs 1991 and 1992, the rebate for sole source and innovator multiple source drugs is the greater of 12.5 percent of the AMP or the difference between the AMP and the manufacturer's "best price" for that drug (excluding the depot and single award contract prices of any agency of the Federal government). In CY 1991, the maximum rebate is 25 percent of the AMP. In CY 1992, the maximum rebate is 50 percent of the AMP. In CY 1993 and thereafter, the rebate is the greater of 15 percent of the AMP or the difference between the AMP and the manufacturer's "best price," with no maximum rebate.
- d. Inflation Adjustment for Single Source and Innovator Drugs - In addition, an inflation adjustment is added to the rebate for single source and innovator multiple source drugs to reflect the difference between the AMP on 10/1/90 and the AMP in subsequent years. Prior to 1994, the index is calculated on a drug-by-drug basis in quarters subsequent to 1/1/91. Beginning in 1994, the index is calculated on an aggregate basis for each manufacturer's product line, weighted for volume in each State. The "best price" is not indexed.
- e. Non-Innovator Rebates - The rebate for non-innovator multiple source and over-the-counter drugs will be 10 percent of the AMP in CYs 1991 through 1993 and 11 percent of the AMP thereafter.
- f. State Limitations - States may impose prior authorization requirements for covered prescription drugs so long as such programs provide a 24-hour response and patients must have access to a 72-hour supply of prescribed restricted drugs in emergency situations. The prior authorization provisions are effective 7/1/91. States may also limit the amount and number of refills for prescription drugs. The law excepts new drugs from any State restrictions for six months following Food and Drug Administration (FDA) approval.
- g. Drug Use Review Program - By 1/1/93, States must provide for a drug use review program to assure that prescriptions are appropriate, medically necessary and are unlikely to produce adverse effects. Prospective drug use review (including counseling) must be performed before prescriptions are filled or delivered, typically at the point of sale or distribution, and must include screening for drug interactions, incorrect dosage or duration, or clinical abuse. Retrospective drug utilization review must be performed through the State's mechanized drug claims processing system to identify patterns of fraud, abuse or inappropriate care.

- h. Electronic Claims Management - The Secretary must encourage States to process claims for outpatient drugs with point-of-sale electronic systems.
- i. Other - A four-year moratorium is imposed on reductions in payment rates to pharmacists and contains other miscellaneous requirements for studies and demonstration projects.
- j. Funding -- After 7/1/91, Federal matching payments for innovator multiple source drugs will be denied where a cheaper generic drug could have been dispensed. For FY 91, an enhanced match of 75 percent for start-up administrative costs of the rebate program is available. For FYs 1991 through 1993, an enhanced match of 75 percent is provided for state drug use review programs. For FYs 1991 and 1992, an enhanced match of 90 percent is available for purchase of electronic point-of-sale claims management systems. [Sec. 4401]

PRIVATE INSURANCE

- a. Medicaid Payment of Premiums and Cost-Sharing for Enrollment under Group Health Plans - Effective 1/1/91, States are required, in accordance with the Secretary's guidelines, to pay premiums for employer-based group health insurance on behalf of Medicaid recipients (and other ineligible family members whose enrollment in the plan is a condition of the Medicaid recipient's enrollment) when it is cost-effective to do so. Enrollment in the group plan is a condition of Medicaid eligibility except in the case of eligible children whose parents fail to enroll them.

States are also required to pay other cost-sharing under the group plan but only to the extent that such cost-sharing amounts are for services that would otherwise be covered under the State's Medicaid plan. For these services, States are required to pay the full cost-sharing amounts as set by the insurer. Recipients are liable for cost-sharing amounts only to the extent that they would be liable if they were not enrolled in the group plan. In addition, States must provide to eligible recipients any services that are covered under Medicaid but not under the group plan in which they are enrolled. In cases where the group plan has minimum enrollment periods, States have the option to continue to pay premiums and cost-sharing under the plan for up to six months after the individual ceases to meet Medicaid eligibility requirements.

Erroneous payments made by States under this provision are not subject to Medicaid quality control penalties. [Section 4402]

- b. Premiums for COBRA Continuation Coverage - Effective 1/1/91, States may pay premiums for individuals who are entitled under COBRA to elect continued coverage under the group health plan of a former employer. The income of such individuals must not exceed 100 percent of the Federal poverty guidelines, and their resources must not exceed twice the maximum level allowed under the Supplemental Security Income (SSI) program (\$4000 in 1991, or twice the SSI level of \$2000 for an individual). State payment of COBRA premiums is permitted only in cases in which the State determines that the payments for the COBRA premiums are likely to be lower than payments for services available under the State's Medicaid plan. [Section 4713]

QUALIFIED MEDICARE BENEFICIARIES

Medicaid benefits for Qualified Medicare Beneficiaries (QMBs) are expanded in three ways. First, coverage of QMBs is accelerated by one year. Effective 1/1/91, most States are required to pay full Medicare cost-sharing (premiums, deductibles, coinsurance for Medicare Parts A and B) for QMBs with incomes below 100 percent of Federal poverty guidelines. (The phase-in date for certain "209(b)" States is 1/1/92.) Second, States must pay Medicare Part B premiums (but no other cost-sharing) for QMBs with incomes between 101 and 110 percent of poverty in 1993-4, and between 101 and 120 percent of poverty in 1995 and thereafter. Third, effective 1/1/91, States must disregard annual cost-of-living adjustments (COLAs) in Social Security benefits paid under title II of the Act when they determine income eligibility of QMBs. This disregard applies in the first month in which the COLA is paid in a year to the month following the month in which revised Federal poverty guidelines are published. [Sec. 4501]

IMPROVEMENTS IN CHILD HEALTH

- a. Phased-in Mandatory Coverage up to 100 Percent of Poverty - Effective 7/1/91, States must extend Medicaid eligibility to all children under age 19 who were born after 9/30/83, in families with incomes at or below 100 percent of the Federal poverty line. Thus, coverage of all such children will be fully phased in in 2002. (States continue to be required to cover younger children - up to age 6 - at a higher level of poverty - 133 percent.) [Sec. 4601]
- b. Mandatory Outreach - States are required to allow pregnant women and children to receive and submit applications for Medicaid at locations other than AFDC offices, including hospitals that serve a disproportionate share of Medicaid and other low-income patients and Federally qualified health

centers, effective 7/1/91. The provision also requires States to use applications other than those used for Aid to Families with Dependent Children. [Sec. 4602]

- c. Mandatory Continuation of Benefits for Pregnant Women and Infants - States are required to continue Medicaid eligibility throughout pregnancy and the applicable post-partum period to eligible pregnant women who would otherwise lose eligibility due to a change in income. In addition, States are required to continue Medicaid eligibility throughout the first year of life for an infant born to a Medicaid-eligible pregnant woman, so long as the infant remains in the woman's household and the woman remains eligible or would remain eligible if she were still pregnant. Effective 1/1/91. [Sec. 4603]
- d. Restrictions on Limits for Hospital Services Furnished to Children under Six - State flexibility is limited in the limits they may impose on medically necessary inpatient hospital services used by children under age one in any hospital and under age 6 in hospitals serving a disproportionate share of Medicaid or other low income patients. First, limits on days of hospital care are prohibited. Second, dollar limits are prohibited except as these result from a general system of prospectively determined payment rates. Third, States with such prospectively determined rates must provide for outlier adjustments in payments for exceptionally high cost or long-stay cases. Effective 7/1/91. [Sec. 4604]
- e. Presumptive Eligibility - Effective 7/1/91, the current presumptive eligibility option is revised by extending the period of time within which a pregnant woman must file an application for regular Medicaid benefits to the last day of the month following the month in which she was determined presumptively eligible. The presumptive period ends on this date if the woman does not file a regular Medicaid application. If she files on time, then she remains presumptively eligible until the State makes a determination about her eligibility under the standard rules. [Sec. 4605]
- f. Role in Paternity Determinations - Effective on enactment, pregnant women applying only for Medicaid coverage for prenatal, delivery, and post-partum care are exempted from the general eligibility requirement to cooperate with the State in establishing paternity and obtaining child support or support for herself or payments for medical care from any third parties. [Sec. 4606]
- g. Report and Transition on Errors in Eligibility Determinations - The Secretary is required to report to Congress by 7/1/91, on error rates by States in determining Medicaid eligibility for pregnant women and infants. The Secretary is required to

exclude expenditures for pregnant women and infants from the calculation of error rate penalties for payments made for assistance provided on or after 7/1/89 and before the first calendar quarter that begins more than 12 months after the report is submitted. [Sec. 4607]

VOLUNTARY CONTRIBUTIONS AND STATE TAXES

- a. State Taxes - States are permitted to receive Federal matching payments for the State share of Medicaid expenditures that are derived from provider-specific taxes, except that the amounts attributable to such taxes are to be excluded from the costs of institutional providers for the purposes of Medicaid reimbursement effective 1/1/91.
- b. Moratorium on New Regulations -- The existing moratorium on the issuance of final regulations regarding the use of voluntary contributions for the State share of Medicaid expenditures is extended one year, until 12/31/91. [Sec. 4701]

DISPROPORTIONATE SHARE HOSPITAL

- a. Counting of Inpatient Days - In calculating a hospital's Medicaid utilization rate for purposes of determining eligibility for, and the amount of, Medicaid disproportionate share payments, a State must include all Medicaid days, including nursery, psychiatric, and administrative days, effective 7/1/90. [Sec. 4702]
- b. Alternative State Payment Adjustments and Systems
 - o In meeting the requirement to provide a payment adjustment to disproportionate share hospitals, State Medicaid programs may use a formula that results in different payments to different types of such hospitals, so long as each hospital in a given category is treated equally. Disproportionate share payments to a hospital must be reasonably related to the costs, volume, or proportion of services provided to Medicaid or low-income patients served by that type of hospital.
 - o The proportionality requirement in prior law applies to payment adjustments for hospitals identified based on low-income utilization rates, as well as the Medicaid inpatient utilization rates.
 - o The sunset requirement is removed for the provision that allows Texas to employ an alternative disproportionate payment methodology.

Effective date: As if included in OBRA-87. [Sec. 4703]

FEDERALLY-QUALIFIED HEALTH CENTERS

- a. Subcontractors - Federally qualified health centers (FQHCs) that do not contract directly with the State Medicaid agency as HMOs, but that subcontract with HMOs that do, must be reimbursed for 100 percent of reasonable costs. In addition, the State must make appropriate payment adjustments to the HMO contractor to reflect these cost-related payments to the HMO's subcontractors.
- b. Indian Health Service Clinics - Indian Health Service clinics operated by a tribe or tribal organization are to be included in the definition of rural health clinics.

Effective as if included in OBRA-89. [Sec. 4704]

HOSPICE

- a. Payments - States are required to pay amounts for room and board for Medicaid recipients who are hospice patients in nursing facilities that are no lower than room and board amounts paid under Medicare. Effective as if included in OBRA-89. [Sec. 4705]
- b. Election - The services that terminally ill Medicaid beneficiaries must waive in electing to receive hospice services include the services of another hospice, services related to treatment of the individual's terminal condition, and services determined to be equivalent (or duplicative of) hospice care. The waiver applies to services otherwise payable by Medicare. Effective upon enactment. [Sec. 4717]

DISALLOWANCES

- a. Psychiatric Services Under Age 21 - Limits the amount of disallowances that may be taken for States' failure to comply with certification of need requirements for certain inpatient psychiatric services furnished to adolescents (under age 21) prior to the date of enactment. (Recently, several States have been audited by the Office of the Inspector General (OIG) and found to be out of compliance, resulting in substantial disallowance of Federal financial participation (FFP)). Also limits the amount of recovery to 25 percent of the disallowance, and the time periods for which a disallowance may be charged are specified. Effective for disallowance actions and deferrals of FFP for services provided before enactment. [Sec. 4706]

- b. Indiana - Permits deferral, without interest, of the payment of a disallowance against the State of Indiana related to failure to survey and certify certain facilities between 1982-1984, until all appeals have been exhausted. Effective upon enactment. [Sec. 4707]

SUBSTITUTE PHYSICIANS

Permits a physician to bill for services provided on a temporary basis to his or her patients by another physician. Effective for services provided on or after the date of enactment. [Sec. 4708; see Section 4110 of OBRA 90 for a parallel Medicare provision.]

HOME AND COMMUNITY-BASED CARE FOR THE FRAIL ELDERLY

- a. Eligibility - As a Medicaid option, allows for the provision of home and community care (HCC) to functionally disabled, elderly individuals who are either medically needy or eligible for Medicaid due to receipt of SSI benefits. In determining eligibility of medically needy individuals, States may take into account anticipated medical expenses for up to six months. States may limit eligibility on the basis of "reasonable classifications" based on age, disability, or need for service. States may waive requirements related to statewideness.

Functionally disabled elderly individuals are individuals who are at least 65 years old with limitations in two out of three specified activities of daily living (ADLs) (toileting, transferring and eating), or with Alzheimer's disease and at least two out of five specified ADL limitations (bathing, dressing, toileting, eating and transferring) or another cognitive impairment that results in behaviors that are dangerous to self or others.

Individuals residing in a State that discontinues a home and community-based waiver subsequent to the election to provide HCC are deemed to qualify for HCC if such individuals would have qualified for Medicaid under the waiver.

Individuals are also deemed to qualify for HCC if they live in a State which used a health insuring organization before 1986; are disabled or at least 65 years of age; meet the test of functional disability under that State's 1115 waiver for personal care services; and have income and resources that meet certain requirements for people in institutions.

Individuals are to be determined as functionally disabled by an interdisciplinary team through an assessment instrument

developed or approved by the Secretary based on a minimum data set developed by the Secretary.

- b. Services - HCC services are to be provided in accordance with a written, individual community care plan (ICCP), developed, reviewed and revised by a qualified community care case manager. The case manager is responsible for assuring delivery of services included in the ICCP. Services can be provided in small (more than 2, less than 8 unrelated individuals) or large (more than 8) residential or non-residential community care settings (CCS) that meet certain minimum standards.

HCC services include: personal care services, chore services, respite care, adult day-care, homemaker/home health aide, nursing services (furnished by or under supervision of a registered nurse), training of family members, services for individuals with mental illness, and other services defined by the State and approved by the Secretary (exclusive of room and board).

- c. Quality - The Secretary is to issue regulations (proposed by 12/1/91 and final by 10/1/92) regarding assessments, case manager qualifications, and requirements for community care settings (CCS). Requirements for CCS include provision of certain rights including freedom from abuse, neglect and restraints and specific limitations on the use of drugs; applicable zoning and fire safety codes; and protection of health and safety. The Secretary is to establish guidelines for competency and compensation of service providers and develop a survey protocol for use by both the States and the Federal government.
- d. Certification - States are required to certify non-State operated providers and CCSs, and the Secretary is required to certify State-operated providers and CCSs. Certification of providers is based on a review of performance. Certification of CCSs is based on an unannounced survey. States are required to investigate and make findings regarding allegations of abuse. The Secretary is required to conduct validation surveys of a specified sample of CCS and conduct special surveys as needed. The Secretary's determinations are binding.
- e. Enforcement - Enforcement options for provider noncompliance must include, at a minimum, civil money penalties (CMPs) and termination. The time between the identification of deficiencies and imposition of sanctions is to be minimized. There is no requirement for the imposition of specific sanctions (e.g., termination) in the event of a serious and immediate threat to health and safety. Individuals who announce a survey are subject to CMPs.

- f. Payment - Federal payments to each State for HCC services in a quarter cannot exceed, in the aggregate, 50 percent of the average skilled nursing facility per diem rate multiplied by the average number of individuals receiving HCC services times the number of days in a quarter. Payment is to be "reasonable and adequate to meet the costs of providing care, efficiently and economically". Payment is not available for CMPs and related costs, or for frivolous litigation. The statute prohibits the Secretary from limiting the amount of Medicaid payment that a State may provide for HCC.

Federal matching payments to all States for this purpose are capped at \$580 million over five years, to be distributed to each State that chooses to participate in HCC, based on the proportion of elderly (or low income elderly) individuals residing in each participating State in relation to the total number of such individuals nationally.

States that elect to provide HCC are obligated, without regard to the availability of Federal funds, to provide HCC to eligible individuals for the duration of an election period.

- g. Effective Dates - Most requirements take effect 7/1/91 (exceptions: determinations of functional disability and CMPs). Requirements take effect whether or not regulations are issued. [Sec. 4711]

COMMUNITY SUPPORTED LIVING ARRANGEMENTS FOR THE MR/DD

- a. In General - Establishes an option within the Medicaid program allowing two to eight States to provide community-supported living arrangements services for certain developmentally disabled individuals.
- b. Eligibility - Community supported living arrangements are available to certain developmentally disabled individuals who are otherwise eligible for Medicaid and living in their own or their family's home, apartment, or other rental unit in which no more than three other individuals receiving these services reside.
- c. Services - Benefits are limited to: personal assistance, training and habilitation services, 24-hour emergency assistance, assistive technology, adaptive equipment, and support services for community activities and other services approved by the Secretary.
- d. Quality Assurance - States are to survey and certify providers in accordance with standards established by the States. Services must be provided under an individual support plan.

State Planning Councils for developmental disabilities must review State Medicaid plans for community supported living arrangements. States must hold public hearings before these plans are adopted. Federal regulations are required to specify measures to protect clients for abuse or neglect.

- e. Federal Payment - Federal matching payments are capped at \$100 million over five years and are to be provided to two to eight States selected by the Secretary. [Sec. 4712]

Effective date: 7/1/91 or 30 days after publication of regulations setting forth interim requirements for State quality assurance programs.

SPOUSAL IMPOVERISHMENT

Three points are clarified. First, in determining how to allocate a couple's income when one spouse is institutionalized and the other is in the community, a State must use its regular eligibility rules in the initial determination and any subsequent redeterminations of the institutionalized spouse's eligibility. (In some cases, the regular rules are the State's generally applicable community property rules.) Second, in determining how much of the institutionalized spouse's income is to be protected for the community spouse and how much must be applied to the cost of institutional care, all States must follow Federal rules, even if these produce different results from the State's own community property or other rules. Third, States must compute each spouse's share of the couple's resources only once, as of the beginning of the first continuous period of institutionalization.

Effective as if included in the Medicare Catastrophic Coverage Act of 1988. [Sec. 4714]

MISCELLANEOUS ELIGIBILITY AND COVERAGE PROVISIONS

- a. German Reparation Payments - In counting the income of certain persons who are expected to pay part of the cost of their care, States must exclude any reparation payments made to Holocaust victims by the Federal Republic of Germany. Effective for months beginning more than 30 days after enactment. [Sec. 4715]
- b. Medicaid Welfare Reform Transition - States are permitted to adopt a "good cause" exception to the current reporting requirements during the first six months of transitional Medicaid coverage for families that lose cash assistance due to earnings. States are prohibited from imposing reporting requirements more frequently than once every quarter. Prior law only allowed a "good cause" exception for reporting during

the second six-months of the transition period. States must give notice 10 days before benefits under this section may be terminated.

Effective as if included in the Family Support Act of 1988.
[Sec. 4716]

- c. Medically Needy Income Levels - States which, as of 6/1/89, based their medically needy income limit for a family of one on the Aid to Families with Dependent Children (AFDC) maximum payment for a family of two may continue to do so. [Sec. 4718]
- d. Rehabilitation Services - Codifies the current regulatory definition of optional rehabilitation services. [Sec. 4719]
- e. Personal Care Services
 - o Minnesota - For fiscal years before 1995, personal care services in Minnesota that are considered to be medical assistance are defined as those prescribed by a physician; provided by an unrelated, qualified person; supervised by a registered nurse; and furnished in a home or other location (other than a hospital or nursing facility). [Sec. 4720]
 - o General - In FY 1995 and thereafter, personal care services are included as part of the Medicaid home health benefit, and the definition of personal care services in Minnesota will apply nationwide. [Sec. 4721]
- f. Substance Abuse Coverage - Current HCFA policy with respect to Medicaid coverage for substance abuse treatment is codified. [Sec. 4722]
- g. Medicaid Spend-down Option - Gives States the option of allowing families, at the family's option, to establish eligibility for medically needy coverage by paying the State up front an amount equal to the difference between income and the income eligibility threshold, reduced by unpaid expenses, if any, incurred for medical care in previous months. Effective upon enactment. [Sec. 4723]
- h. Disability Determinations - States are permitted to make their own determinations of whether a person is disabled or not, using the disability criteria of the SSI program, even if a disability application is pending before or on appeal with the Social Security Administration (SSA). These State determinations govern until a final decision is made by SSA. [Sec. 4724]

HEALTH MAINTENANCE ORGANIZATIONS

- a. Incentive Payments to Physicians - Subjects HMOs, health insuring organizations (HIOs), and other prepaid plans participating in Medicaid on a risk basis, to the same requirements relating to physician incentive payments as those applicable to HMOs participating in Medicare under section 4204 of OBRA-90. [Sec. 4731]
- b. 75 Percent Rule - Provides that the Secretary, in waiving the minimum 25 percent private enrollment requirement with respect to a public entity, need not consider whether special circumstances warrant the waiver. Effective upon enactment. [Sec. 4732(a)]
- c. Medicare Competitive Medical Plans - Extends to entities that contract with Medicare as competitive medical plans existing authority for States to guarantee enrollment in HMOs for six months and to restrict disenrollment from HMOs for six months. Effective upon enactment. [Sec. 4732(b)]
- d. Automatic Re-enrollment - Allows a State, with respect to a Medicaid-eligible individual who is enrolled in an HMO and who loses and regains eligibility within a 3-month period, to re-enroll the individual in the same HMO in which he or she was enrolled at the time he or she lost eligibility. Effective upon enactment. [Sec. 4732(c)]
- e. Provisional Qualification - Deletes obsolete language relating to provisional Federal qualification of HMOs. Effective upon enactment. [Sec. 4732(d)]
- f. Extension and Expansion of Minnesota Prepaid Medicaid Demonstration Project - Extends the on-going Minnesota prepaid demonstration project until 6/30/96, and allows the state to expand the project to additional counties if budget neutral. [Sec. 4733]
- g. County-operated Health Insuring Organizations - Allows the State of California to initiate up to 3 county-sponsored health insuring organizations meeting certain requirements. Effective as if included in the Consolidated Omnibus Budget Reconciliation Act of 1985. [Sec. 4734]

WAIVER PROJECTS

- a. Home and Community-based Service Waivers
 - o Treatment of room and board - Provides that the prohibition against payments for "room and board" under the home and community-based waiver authority does not apply to payments

- made for the share of rent or food costs attributable to the personal care-giver of an individual who would require institutionalization if the care-giver did not reside with the individual. [Sec. 4741(a)]
- o Adjustment to 1915(d) ceiling - Provides that expenditure estimates for purposes of section 1915(d) long-term care waivers must be adjusted to take into account the costs of implementing nursing home reform as enacted in OBRA-87. [Sec. 4741(b)]
 - o Treatment of persons with mental retardation in a decertified facility - Clarifies that, in documenting budget neutrality under a home and community-based waiver for individuals with mental retardation or a related condition, States may continue to count the expenditures for the clients in an ICF/MR terminated from the Medicaid program as if the facility had not been terminated. Effective date: As if included in OBRA-81, but applicable only to facilities terminated after enactment. [Sec. 4742(c)]
 - o Scope of respite care - Clarifies that the Secretary may not restrict the number of hours of respite care that a State may offer under a budget-neutral home and community based waiver. Effective date: As if included in OBRA-81. [Sec. 4742(d)]
 - o Permitting adjustment in estimates - Allows States with operational home and community-based waivers for individuals with mental retardation or related conditions to make adjustments in their utilization and expenditure estimates to reflect the implementation of the preadmission screening and resident review program (PASARR) under nursing home reform. Applies for estimates with respect to expenditures on or after 1/1/89. [Sec. 4742(e)]
- b. Timely Payment under Waivers of Freedom of Choice of Hospital Services - Provides that, in the case of a freedom of choice waiver under section 1915(b)(4) of the Social Security Act, States must meet the same prompt payment standards with respect to hospitals under these waivers as they are currently required to meet in the case of health care practitioners. [Sec. 4742(a)].

DEMONSTRATION PROJECTS

- a. Frail Elderly Demonstration Project Waivers - Expands from 10 to 15 the number of frail elderly demonstration projects patterned after the On Lok project. Clarifies that spousal impoverishment protections apply to individuals receiving

services from these projects on the same basis as they apply to individuals under home and community-based services waivers. [Sec. 4744]

- b. Demonstration Projects to Extend Medicaid Eligibility to Low-income families - The Secretary is directed to allow up to four (but not less than three) States to conduct demonstration projects over a three-year period for the purpose of testing the effect of eliminating categorical Medicaid eligibility requirements for individuals with family incomes below 150 percent of the Federal poverty level. A total of \$40 million in Federal Medicaid matching funds is made available at regular matching rates to participating States for these demonstrations during fiscal years 1991 through 1994. [Sec. 4745]
- c. Medicaid Respite Demonstration Project Extended - Extends the New Jersey respite care demonstration, originally authorized under OBRA-86, through 9/30/92. [Sec. 4746]
- d. Three Year Demonstration Project to Provide Medicaid Coverage for HIV-Positive Individuals - The Secretary is directed to establish two demonstration projects to provide coverage for a broad range of services in addition to the standard Medicaid benefit package to individuals who are infected with the HIV virus and whose income and resources do not exceed State's highest eligibility levels. Each demonstration is to be conducted through one hospital and one other nonprofit organization, and each demonstration is limited to 200 participants. The purpose of the demonstration, for which \$30 million in Federal matching funds will be available during fiscal years 1991-1993, is to compare the costs of treating HIV-positive individuals at an early stage with those treated at a later stage. [Sec. 4747]

OTHER PROVISIONS RELATING TO MEDICAID

- a. Advance Directives - Requires hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, and health maintenance organizations that participate in Medicaid to maintain written policies on advance directives, including "living wills" and durable powers of attorney. These policies must involve written information to all adult patients, documentation of the individual's medical record, non-discrimination against an individual because of a decision on an advance directive, and education for staff and the community. Requires the Secretary to inform providers, beneficiaries, and others, and to assist States. Effective for services furnished on or after the first day of the month beginning more than one year after the date of enactment. [Sec. 4751; see Sec. 4206 for comparable

Medicare provision.]

b. Improvement in Quality of Physician Services

- o Use of unique physician identifiers - Directs the Secretary to establish for use by 7/1/91, a system providing a unique identifier for each physician who provides services to Medicaid beneficiaries. The identifier must be included on all claims submitted for Medicaid payment for physicians' services. [Sec. 4752(a)]
- o Maintenance of encounter data by HMOs - Requires that all prepaid plans contracting on a risk basis with Medicaid maintain sufficient encounter data to identify the physician who delivers services under the plan to patients. Effective for contracts established after the systems for unique physician identifiers are in place. [Sec. 4752(b)]
- o Maintenance of list of physicians - Requires each State to maintain and update (at least monthly) a list of physicians participating in Medicaid and of their unique identifiers. Effective for expenditures in calendar quarters beginning 60 days after the systems for unique physician identifiers are in place. [Sec. 4752(c)]
- o Foreign medical graduate certification - Prohibits the issuance of a unique identifier to a foreign medical graduate who has not, as of 1/1/92, passed the FMGEMS or ECFMMG examinations, or been licensed by one or more States since 1958. [Sec. 4752(d)]
- o Minimum qualifications for billing for physicians' services to children and pregnant women - Effective 1/1/92, establishes minimum qualifications, other than State licensure, which physicians must meet in order to receive payment for services provided to Medicaid-eligible children under 21 or to pregnant women. Allows physicians who do not meet these standards to apply to the Secretary for certification. [Sec. 4752(e)]
- o Reporting of misconduct or substandard care - Requires States to report to the Secretary any negative action or finding by State licensing authorities, peer review organizations, or private accreditation entities reviewing the services provided by practitioners under Medicaid. Effective 1/1/92. [Sec. 4752(f)]

c. Clarification of Authority of Inspector General - Clarifies that the Secretary of HHS may delegate the authority to administer Medicare and Medicaid civil money penalty and exclusion authorities to the Inspector General of HHS. Effective on enactment. [Sec. 4753; see Sec. 4207(j) for a

parallel Medicare provision.]

- d. Notice to State Medical Boards - Requires the State Medicaid agency to notify the State medical licensing board when a physician is terminated, suspended, or otherwise sanctioned. Effective 60 days after enactment. [Sec. 4754]
- e. Psychiatric Hospitals [Sec. 4755]
 - o Clarifies that the Medicaid coverage of inpatient psychiatric services for children under 21 may be extended by Federal regulation to include services beyond those provided by psychiatric hospitals as defined for Medicare purposes. Effective date: As if included in the Deficit Reduction Act of 1984.
 - o Establishes intermediate sanctions for psychiatric hospitals found to be out of compliance with conditions of participation. Effective upon enactment.
- f. State Utilization Review Systems - Prohibits the Secretary from promulgating final regulations requiring States to adopt ambulatory surgery, preadmission testing, or same-day surgery programs until 180 days after submitting to the Congress a report on the effects of such programs on access, quality, and costs of care. Effective upon enactment. [Sec. 4755]

VII. NURSING HOME REFORM

NURSE AIDE TRAINING REQUIREMENTS

- a. No Compliance Action Before Effective Date of Guidelines - Prohibits the Secretary from taking any compliance action against States that made a good faith effort to comply with the nurse aide training requirements prior to the effective date of HCFA's guidelines.

Prohibits the Secretary from canceling or refusing to enter into an agreement under which States determine compliance of certain Medicare providers when States made a good faith effort to comply with the nurse aide training requirements prior to the effective date of HCFA's guidelines.

Effective date: As if included in OBRA-87. [Sec. 4801(a)(1) and 4008(h)(1)(A). Note that many of the nursing home reform provisions are contained in comparable provisions for Medicaid and Medicare.]

- b. Part-Time Nurse Aides Not Allowed a Delay in Training -

Prohibits, after 1/1/91, the use of untrained nurse aides in facilities on a temporary, per diem, leased or any basis other than as permanent employees. Effective date: As if included in OBRA-87. [Sec. 4801(a)(2) and 4008(h)(1)(B)]

- c. Requirement to Obtain Information From Nurse Aide Registry - Requires facilities to inquire of the registry in any State (that is, including States other than the State in which the facility is located) when the facility has reason to believe that the registry will include information about an aide. Effective date: As if included in OBRA-87. [Sec. 4801(a)(3) and 4008(h)(1)(c)]
- d. Retraining of Nurse Aides - Permits an individual who was a nurse aide but who has not worked for compensation for at least 24 months as a nurse aide to take either a nurse aide training and competency evaluation program or a competency evaluation program. Effective date: As if included in OBRA-87. [Sec. 4801(a)(4) and 4008(h)(1)(D)]
- e. Clarification of Nurse Aides Not Subject to Charges - Clarifies that the prohibition against charging nurse aides for training materials and textbooks applies only to nurse aides who are employed by or who have received an offer of employment from a facility as of the date the individual begin a nurse aide training program.

Further, the provision requires States to ensure that an individual who is employed as a nurse aide, or who has an offer of employment within 12 months of completing a nurse aide training and competency evaluation program, be reimbursed for the costs of such programs on a pro rata basis during the period during which the individual is employed.

Effective date: As if included in OBRA-87. [Sec. 4801(a)(5) and 4008(h)(1)(E)]

- f. Modification of Nursing Facility Deficiency Standards - Prohibits the approval of nurse aide training programs offered in or by facilities that within the previous two years:
- o Operated under a waiver of nurse staffing requirements (in the case of skilled nursing facilities (SNFs) under Medicare) or operated under such a waiver for a period exceeding 48 hours each week (in the case of nursing facilities (NFs) under Medicaid); or
 - o Were subject to an extended (or partial extended) survey;
 - o Were subject to any of the following sanctions under Medicare or Medicaid:

- a civil money penalty in excess of \$5,000;
- denial of payment;
- temporary management;
- transfer of residents or closure; or
- termination.

Transition Rule: A State may not approve a nurse aide training program offered in or by a nursing facility that as a result of any Federal or State law was subject to the sanctions identified above within a two year period beginning 10/1/88. [Sec. 4801(a)(6) and 4008(h)(1)(F)]

Technical amendments further clarify the requirements of approval of nurse aide training and competency evaluation programs. [Sec. 4801(e)(18) and 4008(h)(2)(J)]

Effective date: As if included in OBRA-87.

- g. Clarification of State Responsibility to Determine Competency
- Clarifies that the State's responsibility to determine competence of nurse aides in facility-based programs cannot be subcontracted to the nursing facility. Effective date: As if included in OBRA-87. [Sec. 4801(a)(7) and 4008(h)(1)(G)]
- h. Extension of Enhanced Match Rate Until 10/1/90 - Extends for one quarter, through 9/30/90, the enhanced match for State activities with respect to nurse aide training programs. Effective date: As if included in OBRA-87. [Sec. 4801(a)(8)]

PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW

- a. No Compliance Action Before Effective Date of Guidelines - Prohibits the Secretary from taking compliance action against any State that made a good faith effort to comply with preadmission screening and annual resident review (PASARR) requirements prior to the effective date of HCFA guidelines. Effective date: As if included in OBRA-87. [Sec. 4801(b)(1)]
- b. Clarification With Respect to Admissions and Readmission - Provides that residents readmitted to a NF from a hospital are exempt from preadmission screening (PAS). In addition, individuals admitted to a NF following a discharge from an acute hospital stay who are certified by a physician as requiring a NF stay of less than 30 days, and who require care at the NF for the same condition for which they were hospitalized are also exempt from PAS requirements. Effective date: As if included in OBRA-87. [Sec. 4801(b)(2)]
- c. Denial of Payment For Certain Residents Not Requiring Nursing Facility Services - Clarifies that Federal financial participation for NF services will not be available for

individuals (1) for whom a PAS or annual resident review (ARR) is required but has not been completed or (2) who do not require the level of services provided by a NF (except for long-term mentally ill or mentally retarded residents not requiring NF services but needing active treatment). Effective date: As if included in OBRA-87. [Sec. 4801(b)(3)]

- d. No Delegation of Authority for Screening and Reviews - Prohibits State mental health authorities or mental retardation and developmental disabilities authorities from subcontracting PASARR responsibilities to NFs or related entities. Effective upon enactment, without regard to the promulgation of regulations. [Sec. 4801(b)(4)]
- e. Annual Reports - Requires States to report annually to the Secretary on the number and disposition of individuals with mental illness or mental retardation who are:
- o Short-term residents needing active treatment but not requiring NF care; and
 - o Not in need of either active treatment or NF services.

Requires the Secretary to include a summary of the information provided by States regarding the individuals identified above in a previously mandated annual report to Congress on NF compliance with OBRA-87 requirements and on the types of enforcement actions taken. Effective date: As if included in OBRA-87. [Sec. 4801(b)(5)]

- f. Revisions of Alternative Disposition Plans - Permits States with approved alternative disposition plans, which may cover screening, review, and alternative placement requirements, to revise such plans, subject to the approval of the Secretary, before 10/1/91. Discharges of inappropriately placed residents must be made no later than 4/1/94. Effective upon enactment of OBRA-90, without regard to the promulgation of regulations. [Sec. 4801(b)(6)]
- g. Definition of Mental Illness - Modifies the definition of mental illness for the purpose of PASARR to mean a "serious mental illness as defined by the Secretary (in consultation with the National Institute of Mental Health)".

This provision also extends the existing exclusion from PASARR of persons with a primary diagnosis of dementia (including Alzheimer's disease) to also exclude individuals with a non-primary diagnosis of dementia and a primary diagnosis that is not a serious mental illness.

Effective date: As if included in OBRA-87. [Sec. 4801(b)(7)]

- h. Substitution of "Specialized Services" for "Active Treatment" Substitutes, for purposes of the PASARR requirements (with respect to NF and State requirements relating to PASARR), the term "specialized services" for the term "active treatment".

Effective upon enactment, without regard to the promulgation of regulations. [Sec. 4801(b)(8)]

ENFORCEMENT PROCESS

No Compliance Action Before Effective Date of Guidelines - Prohibits the Secretary from taking compliance actions against States for failure to meet requirements to establish and impose remedies (under section 1919(h)(2) of the Social Security Act) when such States make a good faith effort to comply with these requirements prior to promulgation of guidelines that establish remedies for facility non-compliance. Effective upon enactment. [Sec. 4801(c)]

SUPERVISION OF HEALTH CARE OF RESIDENTS

At the option of the State, permits nurse practitioners, clinical nurse specialists, or physician assistants who are not employees of a facility to deliver health care to NF residents in collaboration with a physician. Effective date: 10/1/90, without regard to the promulgation of regulations. [Sec. 4801(d)]

OTHER PROVISIONS RELATING TO NURSING HOME REFORM

- a. Assurance of Appropriate Payment Amounts - In Medicaid, requires the Secretary to evaluate State assurances that NF payment rates are reasonable and adequate to meet the costs to "attain or maintain the highest practicable, physical, mental and psychosocial well-being of each resident".

Requires that Medicaid State plan amendments include a detailed description of the specific methodology used in determining appropriate adjustments in payments for NF services.

In Medicare, provides that if the Secretary allows, through regulations, the use of State Medicaid NF rates for the payment of Medicare SNFs (under sec. 1861(v)(1)(E) of the Social Security Act), such regulations are to take into account the costs of services to "attain or maintain the highest practicable, physical, mental and psychosocial well-being of each resident".

Requires the prospective payment rate for Medicare SNFs (i.e.,

the prospective payment rate that may be elected by SNFs with fewer than 1500 Medicare SNF patient days in a cost reporting period) to include the cost of services to "attain or maintain the highest practicable, physical, mental and psychosocial well-being of each resident".

Effective date: As if included in OBRA-87. [Sec. 4801(e)(1) and 4008(h)(2)(A)]

- b. Disclosure of Information on Quality Assessment and Assurance Committees - Provides that the Secretary or the State may require disclosure of records of a quality assessment and assurance committee only for the purpose of determining compliance of the committee with statutory requirements relating to such a committee. Effective date: As if included in OBRA-87. [Sec. 4801(e)(2) and 4008(h)(2)(B)]
- c. Period For Resident Assessment - Extends from four to 14 days after admission the period within which a facility must assess a new resident. Effective date: As if included in OBRA-87. [Sec. 4801(e)(3) and 4008(h)(2)(C)]
- d. Clarification of Responsibility for Services for Mentally Ill and Mentally Retarded Residents - Clarifies that SNFs and NFs are responsible for providing services and treatment required by individuals with mental illness or mental retardation when the State is not required to provide or arrange for such services. Effective date: As if included in OBRA-87. [Sec. 4801(e)(4) and 4008(h)(2)(D)]
- e. Clarification of Extent of State Waiver Authority - Clarifies States' authority to grant waivers of requirements related to nurse staffing requirements in NFs determined by the state to have made diligent efforts to recruit such individuals, when such a waiver would not endanger the health or safety of residents. When licensed nursing services are waived, a registered nurse or physician must be available to the facility by telephone.

Requires the Secretary (for Medicare SNFs) or States (for Medicaid NFs) to notify the ombudsman and the protection and advocacy system for the mentally ill and mentally retarded of nurse staffing waivers that are granted. Requires facilities to notify current and prospective residents and their families of such waivers.

Effective date: As if included in OBRA-87. [Sec. 4801(e)(5) and 4008(h)(2)(E)]

- f. Clarification of Definition of Nurse Aide - Clarifies that registered dietitians are not nurse aides. Effective date: As if included in OBRA-87. [Sec. 4801(e)(6) and

4008(h)(2)(F)]

- g. Charges Applicable in Cases of Certain Medicaid-Eligible Individuals - Provides that a resident who is entitled to Medicaid, but for whom medical assistance payments are not being made due to income in excess of the Medicaid rate for NF services, may not be charged more than the Medicaid rate for such care. Effective upon enactment, without regard to the promulgation of regulations. [Sec. 4801(e)(7)]
- h. Residents' Rights to Refuse Transfers - Provides a right to refuse a transfer to another room within a facility in order to qualify for Medicare or Medicaid coverage without effect on the resident's Medicare or Medicaid eligibility or entitlement, or on the State's receipt of Federal medical assistance. Effective date: As if included in OBRA-87. [Sec. 4801(e)(8) and 4008(h)(2)(G)]
- i. Resident Access to Clinical Records - Provides residents the right to access current clinical records within 24 hours (excluding weekends or holidays) of the resident's or his or her legal representative's request. Effective date: As if included in OBRA-87. [Sec. 4801(e)(9) and 4008(h)(2)(H)]
- j. Inclusion of State Rights Notice in Facility Notice of Rights - Requires SNFs and NFs to include with the written notice of rights, which the resident may request subsequent to admission, any State-developed notice of rights and obligations. Effective date: As if included in OBRA-87. [Sec. 4801(e)(10) and 4008(h)(2)(I)]
- k. Removal of Duplicative Requirement for Qualifications of Nursing Home Administrators - Repeals section 1908 of the Social Security Act. Effective date: When the Secretary promulgates regulations regarding nursing home administrator requirements under Sec. 1919(f)(4) of the Social Security Act. [Sec. 4801(e)(11)]
- l. Clarification of Nurse Aide Registry - Provides that nurse aides "deemed" to have met nurse aide training and competency evaluation requirements must be registered in the State's nurse aide registry. Prohibits States from imposing charges on nurse aides relating to such registry. Effective date: As if included in OBRA-87. [Sec. 4801(e)(12) and 4008(h)(2)(K)]
- m. Clarification on Findings of Neglect - Clarifies that a finding of neglect of a NF or SNF resident cannot be made against an individual for factors beyond his or her control. Effective date: As if included in OBRA-87. [Sec. 4801(e)(13) and 4008(h)(2)(L)]
- n. Timing of Public Disclosure of Survey Results - Requires the

State and the Secretary to make available to the public statements of deficiencies and approved plans of correction within 14 calendar days of notification of the provider. Effective date: As if included in OBRA-87. [Sec. 4801(e)(14) and 4008(h)(2)(M)]

- o. Ombudsman Program Coordination with State Medicaid and Survey and Certification Agencies - Requires States to notify the State long-term care ombudsman of any adverse action taken against NFs or SNFs. Effective date: As if included in OBRA-87. [Sec. 4801(e)(15) and 4008(h)(2)(N)]
- p. Denial of Payment of Legal Fees for Frivolous Litigation - Denies Medicaid reimbursement to NFs with respect to expenses associated with legal action initiated by the facility which is dismissed as frivolous. Effective date: For actions initiated on or after enactment. [Sec. 4801(e)(16)]
- q. Provisions Relating to Staffing Requirements - Requires the Secretary's regulations for NFs and SNFs with respect to providers of medically related social services, dietary services, and activities be at least as stringent as those requirements in place for such providers prior to OBRA-87.

Requires the Secretary to report to Congress by 1/1/92 on the supervisor-to-resident and supervisor-to-care-giver ratios in SNFs and NFs, and to include recommendations on the appropriate ratios.

Effective date: As if included in OBRA-87. [Sec. 4801(e)(17) and 4008(h)(2)(O)]

VIII. OTHER PROVISIONS AFFECTING HCFA PROGRAMS

DISABLED WIDOW(ER)S

- a. Definition of Disability for Disabled Widow(er)s - Conform the definition used for determining disability of widow(er)s under the Social Security Disability Insurance program to that used for workers. This change permits consideration of non-medical factors, such as previous work experience, in determining whether the individual meets the definition of disability. Effective for benefits provided after December 1990.
- b. Protection of Medicaid - Protects Medicaid eligibility in certain States for disabled widow(er)s who lose SSI benefits when they become entitled to income from Social Security. Protection of Medicaid lasts only until they become entitled to Medicare Part A. Months of SSI eligibility are countable towards the waiting periods for Social Security (5 months) and

Medicare (24 months) Effective for benefits provided after December 1990 to persons who applied before the end of 1990. [Sec. 5103]

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Application of Medicare Payment Amounts as a Limit for Certain FEHB Payments - In the case of inpatient hospital services provided to Federal employees health benefits (FEHB) enrollees who are over 65 and not entitled to Part A, prohibits FEHB carriers (excluding prepayment plans) from making payment to a provider for an amount that, combined with beneficiary cost-sharing, would exceed the Medicare payment and cost sharing that would have been applicable if the service was a Medicare service. Providers who on a repeated basis fail to accept the limited FEHB payment as payment in full would be referred by the Office of Personnel Management to HHS. In these cases, the Secretary could invoke appropriate sanctions. Effective date: For contract years beginning on or after 1/1/92. [Sec. 7002(f)]

COMPUTER MATCHING

Revision of Notification Period - Establishes an alternative method to protect individuals' rights to contest findings when a computer match of various data sources is conducted. This provision allows States meeting certain conditions to use a 10-day notification period, as was possible prior to the 30-day period established by the Computer Matching and Privacy Amendments of 1990. Effective date: 90 days after enactment. [Sec. 7201]

VETERANS' PENSIONS FOR NF RESIDENTS

Reduction of Veterans' Pension Benefits for Individuals Receiving Medicaid Nursing Home Benefits - Reduces Veterans' pension payments in the case of Medicaid-eligible nursing facility residents who do not have a spouse or children to \$90 per month. This figure may not be applied to the cost of NF care; it is thus similar to the personal needs allowance. (Previously, Veterans' pension payments were not reduced and were applied to the cost of care before the Medicaid payment was determined. This provision thus transfers liability for payment of NF services for veterans from Federal funding through the Department of Veterans' Affairs to shared Federal-State funding under the Medicaid program.) Effective upon enactment; expires 9/30/92. [Sec. 8003]

REVENUES

- a. Exclusion of the Earned Income Tax Credit - OBRA-90 expands the earned income tax credit. In order to preserve program eligibility of individuals who receive these credits, all income from these credits is excluded from the eligibility calculations for AFDC, SSI, and Medicaid. Effective date: For determination of income after 12/31/90. [Section 11115]
- b. Increase in Dollar Limitation on Amount of Wages Subject to Hospital Insurance Tax - Provides that the maximum taxable wage base for the Hospital Insurance (HI) portion of the FICA tax will be \$125,000 for CY 1991 and will be indexed to increases in covered wages in future years in the same manner as is the wage base for OASDI. Only the HI tax of 1.45 percent is affected by this increase. The \$125,000 wage base is applicable to both employees and the self-employed. (For OASDI, the maximum taxable wage base for 1991 will be \$53,400.) Effective date: 1/1/91. [Sec. 11331]
- c. Coverage of Certain State and Local Government Employees under Social Security and Medicare - Extends FICA taxes (including HI) to State and local government employees who are not covered by either Social Security or their employer's retirement plan. [Sec. 11332]